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**BEFORE THE**
**MEDICAL BOARD OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

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| In the Matter of the First Amended Accusation Against:<br><br>**LINHKIEU THI NGUYEN, M.D.**<br>**3575 Euclid Ave., Ste. 100**<br>**San Diego, CA 92105**<br><br>**Physician's and Surgeon's Certificate No. A 83886,**<br><br>Respondent. | Case No. 800-2019-051998<br><br>**FIRST AMENDED ACCUSATION** |

## PARTIES

1. William Prasifka (Complainant) brings this First Amended Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about July 2, 2003, the Medical Board issued Physician's and Surgeon's Certificate No. A 83886 to Linhkieu Thi Nguyen, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2022, unless renewed.

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## JURISDICTION

3. This First Amended Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2220 of the Code states:

> Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. . .

5. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
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> (1) Have his or her license revoked upon order of the board.
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> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
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> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
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> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
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> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
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> . . .

6. Section 2234 of the Code states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
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> . . .
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> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

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(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

. . .

7. Section 2266 of the Code states:

The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

8. Unprofessional conduct under section 2234 of the Code is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

**COST RECOVERY**

9. Section 125.3 of the Code states:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

(b) In the case of a disciplined licensee that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g) (1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

## FIRST CAUSE FOR DISCIPLINE

### (Repeated Negligent Acts)

10. Respondent has subjected her Physician's and Surgeon's Certificate No. A 83886 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that she committed repeated negligent acts in her care and treatment of Patient A,[1] as more particularly alleged hereinafter:

11. Between in or about 2014, and April 2018, Respondent saw Patient A for her primary care needs. On or about October 2, 2018, at 12:48 p.m., Patient A passed away. According to the death certificate for Patient A, the immediate cause of death was cardiopulmonary arrest. The death certificate also listed spontaneous intracranial hemorrhage and accelerated hypertension as conditions leading to the cause of death.

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[1] References to "Patient A" herein are used to protect patient privacy.

12. Despite commencing treatment of Patient A in or about 2014, Respondent's certified medical records failed to include any records of Patient A's first visit in 2014 or records of any subsequent visits by Patient A in 2014.

13. Respondent's first progress note for Patient A is for a visit that took place on or about December 16, 2015. The progress note for this visit referenced a flu vaccine that Patient A was given on or about February 5, 2015. It also referenced a gynecological history review that was performed on or about November 11, 2015. However, Respondent has no records of any visits by Patient A in 2015 other than the December 16, 2015 visit, including any records of the visits during which the flu vaccine was given and the gynecological history review was performed.

14. On or about November 14, 2016, Respondent had a visit with Patient A. The progress note for this visit referenced a mammogram that Patient A had done in or about November 2014, as well as labs performed in or about August 2015. However, Respondent failed to keep records of the mammogram or labs. During the visit, Patient A's blood pressure was noted to be 142/94. According to Respondent, her custom would have been to instruct Patient A to monitor her blood pressure at home and recommend lifestyle changes to diet and exercise before putting her on blood pressure medication. Respondent, however, failed to document these instructions and recommendations in her progress note.

15. On or about May 4, 2016, Respondent had a visit with Patient A. Respondent failed to review and sign off on this encounter until on or about November 15, 2016.

16. On or about January 25, 2017, Respondent had a visit with Patient A. Respondent failed to maintain a copy of the progress note for this visit in her certified medical records. In addition, Respondent failed to review or sign off on this encounter. According to the progress note for this visit, Patient A's blood pressure was documented as 145/82.[2] However, Respondent added this value to the progress note on or about October 2, 2018, at 8:28 p.m., after Patient A's death. In making this addition, Respondent failed to retain the blood pressure reading initially

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[2] The normal range for blood pressure levels is less than 120/80 mm Hg.

obtained at the visit. Further, the progress note included a list of medications containing losartan[3] and prazosin,[4] which had fill dates occurring in the future, *i.e.*, in August 2018, and September 2018, respectively. According to Respondent, she did not know Patient A was taking prazosin. Nor did Respondent know that Patient A was taking losartan until after Patient A passed away.

17. On or about April 5, 2017, Respondent saw Patient A for a follow-up visit. Respondent failed to maintain a copy of the progress note for this visit in her certified medical records. In addition, Respondent failed to review and sign off on this encounter until on or about June 8, 2017.

18. On or about September 20, 2017, Respondent had a visit with Patient A. The progress note for this visit included a list of medications containing prazosin 2 mg, which was filled on or about September 1, 2017. According to Respondent, she did not always review the medication list and she did not know Patient A was taking prazosin, even though prazosin was included on the medication list for Patient A.

19. On or about October 25, 2017, Respondent had a visit with Patient A. The progress notes for this visit included a list of medications containing prazosin 2 mg, which was filled on or about September 28, 2017. According to Respondent, she did not always review the medication list and she did not know Patient A was taking prazosin, even though prazosin continued to be included on the medication list for Patient A.

20. On or about December 7, 2017, Respondent had a visit with Patient A. The progress note for this visit included a list of medications again containing prazosin 2 mg, which was filled on or about November 22, 2017. According to Respondent, she did not always review the medication list and she did not know Patient A was taking prazosin, even though prazosin continued to be included on the medication list for Patient A.

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[3] Losartan is a prescription medication used alone or in combination with other medications to treat high blood pressure.

[4] Prazosin is also a prescription medication used alone or in combination with other medications to treat high blood pressure. Other uses of prazosin include the treatment of sleep problems associated with post-traumatic stress disorder.

21. On or about April 2, 2018, Respondent had a visit with Patient A. Respondent did not review and sign off on this encounter until on or about October 30, 2018, after Patient A's death. In addition, the progress note included a list of medications containing losartan and prazosin, which had fill dates occurring in the future, *i.e.*, in August 2018, and September 2018, respectively. According to Respondent, she did not know Patient A was taking prazosin. Nor did Respondent know that Patient A was taking losartan until after Patient A passed away.

22. On or about April 25, 2018, Respondent had a visit with Patient A. Respondent failed to review and sign off on this encounter until on or about October 2, 2018, at 8:20 p.m., after Patient A's death. According to the progress note for this visit, Patient A's blood pressure was documented as 135/74. However, Respondent added this value to the progress note on or about October 2, 2018, at 7:48 p.m., after Patient A's death. Respondent also added the following notation: "1st BP 141/97 and repeat manually 135/74." Respondent added this note on or about October 2, 2018, at 7:47 p.m. In making these additions, Respondent failed to retain the blood pressure reading initially obtained at the visit. Further, the progress note included a list of medications containing losartan and prazosin, which had fill dates occurring in the future, *i.e.*, in August 2018, and September 2018, respectively. According to Respondent, she did not know Patient A was taking losartan until after Patient A passed away. Respondent also did not know that Patient A was taking prazosin, even though prazosin continued to be included on the medication list for Patient A.

23. During the timeframe of Respondent's care and treatment of Patient A, Respondent was aware that Patient A was seeing an outside psychiatric provider. According to Respondent, she requested Patient A's psychiatric records from this provider, however, Respondent's chart for Patient A does not include her request for these records.

24. Respondent committed repeated negligent acts in her care and treatment of Patient A, which included, but were not limited to the following:

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A. Respondent failed in her documentation of Patient A's care and treatment by failing to maintain complete medical records for Patient A, including documentation of Patient A's first visit with Respondent in or about 2014 and any subsequent visits in 2014 and 2015 until on or about December 16, 2015; the administration of a flu vaccine on or about February 5, 2015; the gynecological history review performed on or about November 11, 2015; the mammogram performed in or about November 2014; labs performed in or about August 2015; visits occurring on or about January 25, 2017, and April 5, 2017; and Respondent's request for Patient A's records from an outside psychiatric provider.

B. Respondent failed in her documentation of Patient A's care and treatment by failing to document her recommendations and instructions for treating and managing Patient A's elevated blood pressure readings obtained during in-office visits.

C. Respondent failed in her documentation of Patient A's care and treatment by failing to timely sign and close the record of Patient A's May 4, 2016 visit, until more than six months later, *i.e.*, on or about November 15, 2016.

D. Respondent failed in her documentation of Patient A's care and treatment by failing altogether to sign and close the record of Patient A's January 25, 2017 visit.

E. Respondent failed in her documentation of Patient A's care and treatment by failing to timely sign and close the record of Patient A's April 5, 2017 visit, until more than two months later, *i.e.*, on or about June 8, 2017.

F. Respondent failed in her documentation of Patient A's care and treatment by failing to timely sign and close the record of Patient A's April 2, 2018 visit, until more than six months later, *i.e.*, on or about October 30, 2018, after Patient A's death.

G. Respondent failed in her documentation of Patient A's care and treatment by failing to timely sign and close the record of Patient A's April 25, 2018 visit, until more than five months later, *i.e.*, on or about October 2, 2018, after Patient A's death.

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H. Respondent failed in her documentation of Patient A's care and treatment by failing to document the blood pressure reading initially obtained during Patient A's January 25, 2017 visit.

I. Respondent failed in her documentation of Patient A's care and treatment by failing to document the blood pressure reading initially obtained during Patient A's April 25, 2018 visit.

J. Respondent failed in her documentation of Patient A's care and treatment by failing to recognize, amend, and correct the automated editing of Patient A's medication list for the January 25, 2017 progress note, even though the list included two medications, losartan and prazosin, with fill dates occurring in the future.

K. Respondent failed in her documentation of Patient A's care and treatment by failing to recognize, amend, and correct the automated editing of Patient A's medication list for the April 25, 2018 progress note, even though the list included two medications, losartan and prazosin, with fill dates occurring in the future.

L. Respondent failed in her management of Patient A's care and treatment by failing to review and become aware of Patient A's medications prescribed by outside providers, including prazosin and losartan.

## SECOND CAUSE FOR DISCIPLINE

**(Failure to Maintain Adequate and Accurate Medical Records)**

25. Respondent has subjected her Physician's and Surgeon's Certificate No. A 83886 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that she failed to maintain adequate and accurate records regarding her care and treatment of Patient A, as more particularly alleged in paragraphs 11 through 24, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

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## THIRD CAUSE FOR DISCIPLINE

**(General Unprofessional Conduct)**

26. Respondent has subjected her Physician's and Surgeon's Certificate No. A 83886 to disciplinary action under sections 2227 and 2234 of the Code, in that she has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 11 through 25, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

## PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 83886, issued to Respondent Linhkieu Thi Nguyen, M.D.;

2. Revoking, suspending or denying approval of Respondent Linhkieu Thi Nguyen, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code, and advanced practice nurses;

3. Ordering Respondent Linhkieu Thi Nguyen, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: MAR 2 2 2022

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
*Complainant*

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